IC 27-13-41

Chapter 41. Claims

IC 27-13-41-1

Use of diagnostic or procedure codes

Sec. 1. Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this section:

(1) a health maintenance organization and a limited service health maintenance organization shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the health maintenance organization and limited service health maintenance organization pay claims for health care services covered under an individual contract or a group contract; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for health care services covered under an individual contract or a group contract.

As added by P.L.161-2001, SEC.5. Amended by P.L.66-2002, SEC.18.

IC 27-13-41-2

Reimbursement

Sec. 2. If a provider provides health care services that are covered under an individual contract or a group contract:

(1) after the effective date of the most current version of a diagnostic or procedure code described in section 1 of this chapter; and

(2) before the health maintenance organization or limited service health maintenance organization begins using the most current version of the diagnostic or procedure code;

the health maintenance organization or limited service health maintenance organization shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the

date that the health care services were provided.
As added by P.L.161-2001, SEC.5.